U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 29 June 2007

In the Matter of:

R.R.,
Claimant,

CASE NO: 2005-BLA-5851

v.

HOBET MINING, INC.,
Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

Appearances:

Robert Smith, Esquire
For the Claimant

William Mattingly, Esquire
For the Employer

Before: Edward Terhune Miller,
Administrative Law Judge

DECISION AND ORDER - REJECTION OF CLAIM

Statement of Case

This proceeding involves a request for modification of an initial claim for benefits under the Black Lung Benefits Act (Act) as amended, 30 U.S.C. §§ 901 *et. seq.* Claimant filed his

claim after January 19, 2001. The claim is therefore governed by 20 C.F.R. Part 718 (2004).[1] Because Claimant's last coal mine work was in the state of West Virginia, the claim is subject to the law of the United States Court of Appeals for the Fourth Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-202 (1989) (en banc).

Stipulations

1. The length of Claimant's coal mine employment is no less than 20 years (Tr. 11-12);
2. Claimant has one dependent for purposes of augmentation of benefits (Tr. 23); and
3. Dr. Donald Rasmussen is board-certified in internal medicine; he is a NIOSH B-reader; and he has been employed by the Department of Labor to conduct pulmonary examinations on black lung claimants (Tr. 34).

Issues[2]

1. Whether Claimant has pneumoconiosis;
2. Whether Claimant's pneumoconiosis, if proved, was caused by his coal mining employment;
3. Whether Claimant has proved that he is totally disabled;
4. Whether such disability, if proved, was caused by Claimant's pneumoconiosis; and
5. Whether there has been a change in conditions or a mistake in determination of fact which would support a request for modification under § 725.310.

Procedural History

Claimant filed the instant claim for benefits on December 11, 2002. (DX 2). The District Director for the Department of Labor (DOL) denied benefits in a Proposed Decision and Order dated March 1, 2004, because, though Claimant had proved that he had contracted pneumoconiosis from coal mine work, he had not proved that he is totally disabled by the disease. (DX 18). By letter dated October 20, 2004, Dr. Norma J. Mullins requested that the claim be re-opened. (DX 21). The District Director treated Dr. Mullins's letter as a request for modification.[3] (DX 22). On March 16, 2004, the District Director again denied benefits for failure to prove total disability caused by pneumoconiosis. (DX 30). By letter dated April 25, 2005, Claimant requested a hearing with the Office of Administrative Law Judges (OALJ), and

[1] All references to the Code of Federal Regulations are by part or section under Title 20 unless otherwise indicated. Director's exhibits are denoted as "DX;" Claimant's exhibits are denoted "CX;" Employer's exhibits are denoted "EX." References to the transcript of hearing are denoted "Tr."

[2] At the hearing, counsel for Employer represented that timeliness of the claim would not be a contested issue. (Tr. 32).

[3] The Third Circuit has held, in an unpublished decision, that a request for modification is invalid unless it is received from a party. *See Bethenergy Mines v. Director*, Nos. 91-3330 and 98-2750 (3d Cir. Apr. 2, 1992) (unpub.). This authority is not controlling because the instant case arises in the Fourth Circuit. Moreover, Employer has not lodged any objection to the letter being treated as a request for modification, in effect the submission of additional medical evidence.

jurisdiction was transferred to the OALJ on May 6, 2005. (DX 34, 35). A hearing was conducted on February 8, 2006, in Charleston, West Virginia. Claimant appeared and was represented by counsel. Employer appeared by counsel. (Tr. 4).

Background

Claimant was born on August 20, 1950. (DX 2). He has a ninth grade education. (DX 2). On his application for benefits, Claimant reported that at his last job, he was a driller and blaster for Employer. (DX 4). He also reported that he has never smoked cigarettes. (DX 2). He reported that he retired from working in the coal mines in 2002 because he experienced shortness of breath and dizziness to the point of passing out. (DX 2).

At the hearing on February 8, 2006, Claimant testified that he is currently married and has two adult children. (Tr. 14-15). He stated that he began working in the coal mines in 1973 and that his last employer was Employer. (Tr. 15, 17). In the beginning of his career, he worked with older drills and would be covered in dust at the end of the day. (Tr. 17). He testified that when he first went to work for Employer, he ran an older drill that did not have a seat. (Tr. 26). He would have to stand beside it as it operated, and the coal dust would come down his shirt. (Tr. 26 - 27). He stated that sometime in the 1980's Employer purchased a new drill which had a cab on it with windows. (Tr. 27). In addition, Claimant testified that as his career progressed, respirators became more available. (Tr. 26). Prior to working in the coal mines, Claimant spent approximately three years working as a drill operator with a road construction crew. (Tr. 27). During this period, he was exposed to dust created by drilling the roads. (Tr. 28).

Claimant testified that he first started experiencing breathing problems in the early 1990's. (Tr. 18). He explained that it became worse during the last year that he worked in the coal mines, and he would become short of breath from climbing a four-step ladder. (Tr. 18 – 19). He gets winded walking down his driveway and back, which is about three or four hundred feet at an incline. (Tr. 20). He has been unable to keep up with the lawn maintenance at his home because he has difficulty breathing and becomes dizzy. (Tr. 21).

Admissibility of Evidence Under Pertinent Regulations

Dr. Mullins's March 26, 2003 pulmonary function study, arterial blood gas study, and medical report; Dr. Manu N. Patel's reading of the March 26, 2003 x-ray; and Dr. Navani's re-reading of the March 26, 2003 x-ray, offered as Director's Exhibits 8-12, are admissible as evidence generated by the mandatory pulmonary examination provided to Claimant of right under the applicable regulations. § 725.406. Of the various treatment records and correspondence dated December 16, 2000 through July 1, 2004, offered as Director's Exhibit 23, only the pulmonary function tests, arterial blood gas studies, and Dr. Daniel Grinnan's July 1, 2004 History and Physical are admissible as records of medical treatment of Claimant's respiratory or pulmonary disease. § 725.414(a)(4).[4]

[4] Director's Exhibit 23 also contains a letter to Claimant from the U.S. Department of Health and Human Services dated February 16, 2000, which is not a treatment record, medical report, or any other evidence admissible under the Regulations. In addition, DX 23 contains Dr. Mullins's letter to DOL dated October 20, 2004; Dr. Mullins's letter

Claimant has submitted Dr. Donald Rasmussen's September 21, 2005 pulmonary function test, arterial blood gas study, and medical report which are all admissible as Claimant's affirmative evidence under § 725.414(2)(i). Dr. Mullins's March 8, 2004 letter "To Whom It May Concern," contained in Director's Exhibit 23, is admissible as a medical report in support of Claimant's affirmative case under § 725.414(a)(2)(i).

Employer has submitted Dr. George L. Zaldivar's February 9, 2005 x-ray, pulmonary function test, arterial blood gas study, and medical report; a transcript of Dr. Zaldivar's deposition testimony dated February 6, 2006; Dr. William W. Scott's interpretation of the February 9, 2005 x-ray; Dr. Robert J. Crisalli's September 28, 2005 pulmonary function test, arterial blood gas study, and medical report; and a transcript of Dr. Crisalli's deposition testimony dated February 13, 2006. This evidence is admissible as Employer's initial evidence under § 725.414(a)(3)(i). Employer has also submitted Dr. Paul S. Wheeler's interpretation of the March 26, 2003 x-ray, which is admissible as Employer's rebuttal evidence under § 725.414(a)(3)(ii). Finally, Employer has submitted pulmonary function studies performed at West Virginia University Hospital on May 15, 2002, and June 17, 2002, as well as an arterial blood gas study performed at University of Virginia Health System on July 1, 2004. This evidence is admissible as Claimant's treatment records under § 725.414(a)(4).

Medical Evidence

Chest X-ray Evidence

Ex. No.	Physician	B-Reader/ BCR[5]	Date of X-ray	Film Quality	Reading
DX 11	Patel	B/BCR	03/26/03	2	3/2, q/4, all zones; left lower calcified granuloma
DX 12	Navani	BCR[6]	03/26/03	2	Quality only

to Employer dated May 13, 2003; Dr. Mullins's note "To Whom It May Concern" dated July 8, 2003; and Dr. Sarah M. Neases's January 6, 2003 note "To Whom It May Concern." These notes and letters are not treatment records as they summarize Claimant's pulmonary condition and provide rationalizations for the physicians' opinions. *See Presley v. Clinchfield Coal Co.*, BRB No. 06-0761 BLA (Apr. 30, 2007)(unpub.); *Stamper v. Westerman Coal Co.*, BRB NO. 05-0946, July 7, 2006 (unpub). Further, because there are two medical reports in the record as Claimant's affirmative evidence, including Dr. Mullins's March 8, 2004 letter, the remaining notes and letters, which are characterized as medical reports, exceed the evidentiary limitations set forth in § 725.414 and are not admitted.

[5]"BCR" refers to a board-certified radiologist. "B" refers to a NIOSH-certified B-reader. B-reader qualifications are recorded on the B-reader list published on DOL's website. Comprehensive List of NIOSH Approved A and B Readers (February 20, 2007), at http://www.oalj.dol.gov/PUBLIC/BLACK_LUNG/REFERENCES/REFERENCE_WORKS/BREAD3_02_07.HTM The board-certifications of physicians are listed by the American Board of Medical Specialties, at www.abms.org. This tribunal has taken judicial notice of these resources if the qualifications of particular physicians are not otherwise of record. *See Maddaleni v. Pittsburgh and Midway Coal Co.*, 14 B.L.R. 1-135 (1990).

[6] Despite his indication on the x-ray classification form, the Comprehensive List of NIOSH Approved A and B Readers (February 20, 2007) records that Dr. Navani's B-reader certification expired on April 30, 1999.

EX 2	Wheeler	B/BCR	03/26/03	2	1/0, upper and middle right and left zones (??)[7]; some nodules could be CWP but these are mainly in periphery lungs while CWP typically gives small symmetrical nodular infiltrates in central portion mid and upper lungs which are largely spared on this exam; he is also young to have significant CWP because NIOSH became active in controlling dust levels in mines beginning in the 1970s; get better evaluation
DX 28	Scott	B/BCR[8]	02/09/05	2	2/3, q/q, all lung zones (?)[9]; many calcified granulomata; calcified hilar nodes; all changes could be partially healed histoplasmosis or TB; silicosis/CWP cannot be excluded; a histologic diagnosis should be obtained
DX 29	Zaldivar	B	02/09/05	1	r/r, 3/3, all zones; sarcoidosis
CX 1	Rasmussen	B	09/21/05	1	r/r, 1/2, all zones

Pulmonary Function Tests

Ex. No.	**Physician**	**Date**	**Age**	**Ht.[10]**	**Qual.**	**FEV_1**	**FVC**	**MVV**	**FEV_1 / FVC**	**Cooperation Comprehension**
EX 3[11]	Guilfoose/ Teba	05/15/02	51	68.9”	No	2.83 2.96	4.17 4.30	-- --	68% 69%	N/A
DX 10	Mullins	03/26/03	52	68.5”	No	2.88 --	4.16 --	-- --	69% --	Good Good
DX 23[12]	Mullins	03/31/04	53	68.5"	Yes Yes	1.39 1.78	2.36 2.36	110 --	59% 75%	Good
DX 29	Zaldivar	02/09/05	54	69"	No No	2.13 2.47	3.24 3.37	-- --	66% 73%	N/A
EX 1	Crisalli	08/01/05	54	69”	No No	2.46 2.46	3.84 3.44	93 --	64% 71%	Effort variable due to an uncontrollable cough

[7] The question marks appear in the report.
[8] Along with Dr. Scott’s CV, Employer submitted a copy of the NIOSH certificate proving that Dr. Scott was certified as a B-reader. However, that certificate expired on July 31, 2004, and the x-ray dated February 9, 2005, was interpreted on February 15, 2005. (DX 28). The Comprehensive List of NIOSH Approved A and B Readers establishes that he was a B Reader when he interpreted the x-ray on February 15, 2005.
[9] The question mark appears in the report.
[10] The height is indicated as recorded by each physician. The ALJ is required to resolve the height discrepancy contained in the record. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). An average of the reported heights produced a height of 68.6, which is adopted.
[11] This pulmonary function test is admitted as a treatment record under § 725.414(a)(4).
[12] This pulmonary function test is admitted as a treatment record under § 725.414(a)(4).

CX 1	Rasmussen	09/21/05	55	68”	No No	2.50 2.67	3.60 3.62	-- --	70% 74%	Only fair effort

Arterial Blood Gas Studies

Ex. No.	Physician	Date of Study	Altitude	Rest (R) Exercise (E)	pCO_2	pO_2	Comments	Qual.
DX 9	Mullins	03/26/03	0 to 2999	R E	37.9 32.6	67.6 101.2	N/A	No No
DX 23[13]	Walker	04/16/04	0 to 2999	?	38	70	N/A	No
EX 3[14]	Grinnan	07/01/04	0 to 2999	E	36	89	All reported test results met ATS criteria; ABG drawn after exercise; Pt. walked 420 meters very briskly	No
DX 29	Zaldivar	02/09/05	0 to 2999	R	38	78	N/A	No
EX 1	Crisalli	08/01/05	0 to 2999	R	41	77	N/A	No
CX 1	Rasmussen	09/21/05	0 to 2999	R E	37 35	77 61	N/A	No Yes

Physician's Opinions

Dr. Mullins

At DOL's request, Dr. Mullins, who is board-certified in internal medicine with a subspecialty in pulmonary diseases, examined Claimant on March 26, 2003. (DX 8). Dr. Mullins noted a history of high blood pressure and heart disease. Claimant reported that he had never smoked cigarettes, and that he was suffering from wheezing at night, dyspnea on hills and stairs, a cough in the morning, and that he had once experienced chest pain in the evening. Claimant also reported producing thick sticky sputum and taking Combivent, Advair, Singular, and other medications.

On physical examination, Dr. Mullins found that Claimant was overweight and was short of breath when talking. She noted that he occasionally gasped for air, which she felt was indicative of an upper airway obstruction. Claimant's heart was normal, but there was bilateral diffuse wheezing in the lungs.

Dr. Mullins obtained an x-ray which was read by Dr. Patel and classified as 3/2, q/r in all lung zones, as well as a left lower calcified granuloma. (DX 11). Neither her arterial blood gas study nor her pulmonary function tests yielded results which would qualify Claimant as totally disabled under the Regulations. (DX 9, 10). Based on these findings, Dr. Mullins diagnosed Claimant with "[x-ray] consistent with coal dust exposure" and shortness of breath when talking. She listed the etiology of her diagnoses as "unknown, possible upper airway obstruction." Finally, she concluded that despite her diagnoses, Claimant suffered no pulmonary impairment.

[13] This arterial blood gas study is admitted as a treatment record under § 725.414(a)(4).
[14] This arterial blood gas study is admitted as a treatment record under § 725.414(a)(4).

The record contains a note signed by Dr. Mullins "To Whom It May Concern" dated March 8, 2004, in which Dr. Mullins summarized Claimant's condition at the time, opined that Claimant was totally disabled, and explained her rationale for arriving at the conclusion that Claimant was totally disabled.[15] (DX 23). She reported Claimant's pulmonary history as shortness of breath at rest with some gasping and cough. She further stated that Claimant has had problems with near syncope, where he got very weak and felt as though he were going to pass out, but he never lost consciousness completely. In addition, Dr. Mullins noted that Claimant gets short of breath with exertion. She recalled that the results of the DOL-sponsored examination indicated that Claimant had normal pulmonary function, but that "[h]e has had a positive stress test and underwent cardiac catheterization, which revealed a 30% narrowing in the left anterior descending." However, she noted that from a cardiac standpoint, Claimant was doing "fairly well." She also noted that Claimant's exposure to a cleaning agent over several years might have adversely affected his breathing.

In the March 8, 2004 note, Dr. Mullins reported that a CT scan of the neck was done which showed cervical spondylosis and minor adenopathy. A chest x-ray was also performed which revealed bilateral hilar lymph nodes and numerous miliary nodules scattered throughout the lungs, primarily at upper lobe distribution. She noted that she performed a bronchoscopy, the results of which were consistent with DIP, and stated that she had begun steroid treatment for the DIP. She opined that despite some improvement, Claimant was permanently disabled and "definitely not able to return to work" because he was still experiencing shortness of breath on exertion.

Dr. Zaldivar

At Employer's request, Dr. Zaldivar, who is board-certified in internal medicine with a subspecialty in pulmonary diseases and is a NIOSH approved B-reader, examined Claimant on February 9, 2005. (DX 29). In addition to physically examining Claimant, Dr. Zaldivar reviewed Dr. Mullins's report and letter, correspondence to Claimant from the U.S. Department of Health and Human Services (DHHS)[16], and the treatment records that are part of this record. Dr. Zaldivar reported Claimant's work history as working in the blasting crew on a strip mine from 1974 until November 3, 2002. Dr. Zaldivar reported that prior to working in the coal mines, Claimant worked in road construction using a rock drill for approximately three years. He reported a 0-year smoking history.

Claimant reported that he became short of breath climbing stairs, and he experienced wheezing and coughing. He explained that Prednisone helped to relieve the coughing and wheezing, but he had been taken off of the medication and the symptoms were reoccurring.

[15] Because the letter summarizes Claimant's condition and contains an opinion and its rationalization, the note is "'a physician's written assessment of the miner's respiratory or pulmonary condition,' and not a simple record of the miner's 'medical treatment for a respiratory or pulmonary or related disease.'" *Stamper*, BRB NO. 05-0946 (quoting § 725.414). Thus, it is admissible as Claimant's second medical report under § 725.414.

[16] These records are not admissible into evidence; therefore, Dr. Zaldivar's opinions are inadmissible to extent that he has relied upon these records in reaching his conclusions. *See Dempsey v. Sewell Coal Co.*, 23 BLR 1-47 (2004). However, a review of Dr. Zaldivar's report establishes that he did not place any substantial reliance on the inadmissible records in formulating his opinion. Thus, the report is admissible in its entirety.

Claimant stated that at the time of the examination, he was taking Plavix, Toprol, Aspirin, Enalapril, Hydrochlorothaizide, Combivnet, Flovent, Mobic, and Zocor. He reported no history of asthma, emphysema, or tuberculosis, but reported that he had a heart catheterization.

On physical examination, Dr. Zaldivar noted normal lungs and heart. The x-ray of Claimant's chest revealed 3/3, r/r opacities in all lung zones as well as signs of sarcoidosis. The pulmonary function test revealed an FEV1 of 2.13 and a FVC of 3.24 pre-bronchodilator, and an FEV1 of 2.47 and an FVC of 3.37 post-bronchodilator. Dr. Zaldivar interpreted these results to indicate a mild reversible obstruction with normal lung volume with only minimal air trapping and normal diffusion. An arterial blood gas study was also performed which yielded a PCO2 level of 38 and a PO2 level of 78. Dr. Zaldivar interpreted these results to indicate that Claimant had normal resting blood gases.

Based on his examination of Claimant and his review of the medical records, Dr. Zaldivar concluded that there was evidence to justify a diagnosis of simple coal workers' pneumoconiosis, but that there was minimal pulmonary impairment. Dr. Zaldivar's opinion as to the etiology of the impairment is internally inconsistent. First, he stated that "[there] is minimal pulmonary impairment, which is the result of an asthmatic condition not related to his occupation." However, he also noted that Claimant's forced vital capacity was reduced as the result of an airway obstruction which responded to inhalation of bronchodilators, which he concluded was "due to an asthmatic type condition or related to both pneumoconiosis or any other pneumonitis." Finally, Dr. Zaldivar stated that from a pulmonary standpoint, Claimant was capable of performing his usually coal mining work or work requiring similar exertion.

At his deposition, on February 6, 2006, Dr. Zaldivar testified that DIP is a nonspecific diagnosis that is made when there is fibrosis of terminal units in the lungs. (EX 4). Sometimes the DIP is related to smoking or infection, and other times the cause is simply unknown, but in most cases, DIP is progressive and lethal. Sometimes the DIP will respond to the bronchodilator, but sometimes it will not. Coal mining has never been related in any way to DIP. Either way, Dr. Zaldivar stated that whether the Claimant suffered from DIP was still unknown due to the questionable size of the tissue samples produced from the bronchoscopy. Dr. Zaldivar also noted that Claimant had a history of hypertension, which could be the cause of his shortness of breath on exertion.

Also at his deposition, Dr. Zaldivar noted that, while he read and classified Claimant's February 9, 2005 chest x-ray to as 3/3, Dr. Rasmussen read the September 21, 2005 as 1/2. Initially, Dr. Zaldivar noted that he usually reads profusions to be a lot lower than does Dr. Rasmussen, and he deferred to Dr. Rasmussen's interpretation. However, he opined that the difference in the interpretations constituted a "variation" which would not be consistent with coal workers' pneumoconiosis. He noted that such an improvement could, however, be indicative of DIP or sarcoidosis, and that Prednisone, when used to treat sarcoidosis, tends to "melt away the lesions." Thus, Dr. Zaldivar concluded that it "is possible that he has silicosis [or coal workers' pneumoconiosis]. It is also possible that he has sarcoidosis, which may have resulted in DIP, which was treated with the Prednisone." Regardless, Dr. Zaldivar maintained that Claimant suffered from asthma, a condition that he associated with sarcoidosis.

Finally, Dr. Zaldivar expressed concern about the results of Dr. Rasmussen's arterial blood gas studies. Dr. Zaldivar opined that the results of the arterial blood gas studies during exercise were "very, very abnormal" because blood gases do not decrease during exercise. He noted that Dr. Mullins's arterial blood gas studies yielded normal results and that Dr. Rasmussen's pulmonary function test was "almost normal," the diffusion capacity as demonstrated by the arterial blood gas study was normal, and the chest x-ray showed improvement in Claimant's lungs. In addition, he noted that during Dr. Mullins's exercise test, Claimant's PO2 was 101 and stated that therefore "there is no logical explanation for the blood gases to do what they did when Dr. Rasmussen exercised him." Thus, Dr. Zaldivar concluded that the results of Dr. Rasmussen's arterial blood gas, at least those results that were obtained during exercise, were inaccurate.

Dr. Crisalli

At Employer's request, Dr. Robert J. Crisalli, who is board-certified in internal medicine with a subspecialty in pulmonary diseases, examined Claimant on August 1, 2005. (EX 1). In addition to physically examining Claimant, Dr. Crisalli reviewed Dr. Mullins's report and letter, Dr. Zaldivar's report, and the treatment records that are part of this record. Dr. Crisalli reported Claimant's work history as about 30 years at surface coal mines, ending on or about August 29, 2002. Dr. Crisalli noted that prior to working in the coal mines, Claimant worked in road construction for approximately four years. Claimant reported that he never smoked cigarettes, although he had chewed tobacco.

At the time of the examination, Claimant complained of shortness of breath that began around 1990 and had become worse in the two years prior to the date of the examination. He complained of cough productive of sputum that began three to four years prior to the date of the examination and wheezing which he had suffered for two years. Claimant reported that his cough and sputum production was cleared by oral steroids, but that at the time of the examination, he was taking inhaled steroids. Claimant also complained of chest discomfort, but did not take the Nitroglycerin which was prescribed for the discomfort.

At the time of the examination, Claimant's medications included a Flovent inhaler and Combivent inhaler, which he stated were helpful. In addition, he was taking anti-hypertensives and anti-platelet medications. He reported a history of hypertension, coronary artery disease, and arthritis. He complained of weakness, tinnitus, and dizziness.

On physical examination, Dr. Crisalli found a normal heart and lungs. He noted an elevated blood pressure, excessive weight, and protuberant abdomen. The pulmonary function test revealed a mild degree of obstruction to airflow and a moderately severe degree of air trapping. Dr. Crisalli noted that Claimant had difficulty performing the test due to an uncontrollable cough. There was no evidence of a restrictive defect or a diffusion impairment, nor was there improvement after bronchodilators. The arterial blood gas study revealed a mild degree of hypoxemia at rest.

As to his review of the medical records, Dr. Crisalli found that Dr. Mullins's March 31, 2004 pulmonary function study, which was part of Dr. Mullins's treatment records, was not

valid. He noted that the values were lower than the studies done before and since that particular examination, and he questioned the timing of the study as it related to Claimant's transbronchial lung biopsy and steroid treatment. He therefore concluded that the test was not representative of Claimant's baseline status. Dr. Crisalli also questioned the validity of the pulmonary function tests that were performed at the University of Virginia because there were no curves to review.

Dr. Crisalli further questioned the validity of the physicians' statement that the diagnosis of DIP could not be made accurately from the transbronchial lung biopsies. Dr. Crisalli noted that it was unclear whether the physicians at UVA had reviewed any pathology reports in coming to this conclusion and pointed out that Dr. Crisalli himself did not have access to any pathology reports. He stated that usually an open lung biopsy is necessary in order to diagnose DIP, but then stated that "it is possible at times to arrive at this diagnoses [sic] correctly on the basis of transbronchial lung biopsies."

Dr. Crisalli concluded that Claimant had radiographic evidence of coal workers' pneumoconiosis and silicosis, but that it was also possible that the calcified lymph glands noted by Drs. Zaldivar and Scott related to granulomatous disease of the lungs such as tuberculosis or histoplasmosis. As to the DIP diagnosis, Dr. Crisalli stated:

> Based on the only pathology reports that I have, [Claimant] has desquamative interstitial pneumonitis. I do not have any pathologist report to review. I do not know if a pathologist at the University of Virginia actually reviewed the slides. If no pathologist at the University of Virginia actually reviewed the slides, then the physician's [sic] conclusion that desquamative interstitial pneumonitis is ruled out on the basis of the tissue representing a transbronchial lung biopsy is not appropriate.

As to the level of Claimant's pulmonary impairment, Dr. Crisalli opined that Claimant suffered only mild impairment. Thus, Dr. Crisalli concluded that Claimant retained the pulmonary capacity to perform his previous job in the coal mines.

At his deposition on February 13, 2006, Dr. Crisalli elaborated on his diagnosis of DIP. (EX 5). Dr. Crisalli stated that because Claimant seemed to respond to the steroid therapy, the cause of his pulmonary problems was not asthma or COPD; rather, it was more likely sarcoidosis or DIP. Moreover, Dr. Crisalli pointed out that Dr. Rasmussen read the September 9, 2005 chest x-ray to show opacities of a much smaller profusion level than had previously been noted. Thus, Dr. Crisalli opined that these changes could be consistent with DIP. However, Dr. Crisalli was unable to reach a certain diagnosis, and instead made a differential diagnosis of an interstitial lung disease versus coal workers' pneumoconiosis.

Dr. Crisalli also commented on Dr. Rasmussen's arterial blood gas study results obtained on September 21, 2005. Dr. Crisalli, like Dr. Zaldivar, questioned the validity of Dr. Rasmussen's results because of the difference between the PO2 levels in that study and the levels in Dr. Mullins's study. However, on several occasions, Dr. Crisalli indicated that he was under the assumption that Dr. Mullins's arterial blood gas study was performed on March 26, 2005,

and the marked difference in the PO2 levels occurred in only six months. The record does not contain an arterial blood gas study dated March 26, 2005; however, Dr. Mullins did perform an arterial blood gas study on March 26, 2003, and the PO2 level in that study was 101.2, the value that is cited by Dr. Crisalli. Thus, it is reasonable to assume that Dr. Crisalli was mistaken in his assumption that Dr. Mullins's study was performed in March 2005, and in fact he was referring to the study performed in March 2003, which was two and a half years earlier.

Finally, Dr. Crisalli pointed out that Claimant's shortness of breath could be due to his obesity.

Dr. Rasmussen

At Claimant's request, Dr. Donald Rasmussen, who is board-certified in internal medicine, examined Claimant on September 21, 2005. (CX 1). Dr. Rasmussen reported that Claimant was a lifelong non-smoker; that he was employed in the coal mines for a total of 30 years as a driller and a blaster; and that as a blaster, he was required to load bulk, carry bags of powder, and shovel to fill holes.

Claimant complained of shortness of breath which began 15 years prior to the date of the examination and became progressively worse. Claimant stated that he was unable to walk quickly or climb hills. In addition, Claimant complained of a chronic, mostly non-productive cough. He stated that he had little or no wheezing since he began the steroid treatment, but the steroids had not relieved his shortness of breath. Claimant also related to Dr. Rasmussen that he had previously been told that he had coal workers' pneumoconiosis and bronchial asthma. He reported hypertension, but denied any other cardiovascular illness. He told Dr. Rasmussen about the 2002 bronchoscopy and the 2003 cardiac catheterization.

Upon physical examination, Dr. Rasmussen found a diminished chest expansion and minimally reduced breath sounds, but no rales, rhonchi, or wheezes. Heart tones were reduced, but the rhythm was regular and there were no murmurs, gallops, or clicks. Dr. Rasmussen interpreted the chest x-ray as 1/2, r/r in all lung zones, and showing bullae emphysema, and enlarged hilae. Pulmonary function studies were only "fairly performed" and revealed a mild irreversible obstructive ventilatory impairment. Total lung capacity and residual volume were normal, as was the single breath carbon monoxide diffusing capacity. The arterial blood gas study revealed that resting blood gases were also normal, but Claimant's oxygen transfer was markedly abnormal.

Based on his examination, Dr. Rasmussen concluded Claimant suffered from a marked loss of lung function as reflected by his marked impairment in oxygen transfer during exercise, and by his distinct reduction in breathing reserve. Dr. Rasmussen opined that this impairment prevented Claimant from returning to coal mine employment. Dr. Rasmussen stated that the only known cause of the impairment was coal dust exposure, and cited several medical journal articles to support this conclusion.

Treatment Records

Dr. Mullins

On March 21, 2004, Dr. Mullins performed a pulmonary function test on Claimant. (DX 23). The test results contain a note indicating that Claimant had never smoked and that he made a good effort to complete the test. Before the administration of a bronchodilator, Claimant's FEV1 was 1.39 and his FVC was 2.36. After bronchodilator, Claimant's FEV1 was 1.78 and his FVC was 2.36. This was the only pulmonary function test of record with qualifying results.

Dr. Daniel Grinnan, University of Virginia Pulmonary Clinic

The record contains a note from the UVA Pulmonary Clinic dated July 1, 2004. (DX 23). In it, Dr. Grinnan, who is board-certified in internal medicine with subspecialties in pulmonary disease and critical care medicine, states that Dr. Mullins had referred Claimant to him for a second opinion with respect to silicosis versus DIP. Dr. Grinnan reported that Claimant worked in the coal mines for many years operating a sand rock drill and had significant exposure to sand dust. Dr. Grinnan also noted that Claimant never smoked cigarettes and had significant exposure to a cleaning agent called Varso in the 1980s. Claimant told Dr. Grinnan that he had abnormal chest x-rays dating back to the early 1990s and in 1999, he was told to retire due to his pulmonary disease. He retired in 2002 because of his extreme shortness of breath and dyspnea on exertion. He complained of shortness of breath occurring chronically over a 10 to 15 year period but only a mild cough. Claimant reported that he was able to walk a quarter of a mile, but only on a flat surface at a slow rate.

Claimant told Dr. Grinnan about the transbronchial lung biopsy that he underwent in 2003, and he reported that his cough had significantly improved with Prednisone, but that he was tapered off the Prednisone due to osteopenia. He did not have any recurrence of his chronic cough after he was tapered off the Prednisone. Dr. Grinnan noted that at the time of the examination, Claimant was taking Flovent, Combivent, Fosamax, Plavix, Toprol, Aspirin, Enalapril, Hydrochlorothiazide, Singulair, and Sertaline.

On physical examination, Dr. Grinnan noted a normal heart with mild rales and decreased breath sounds in the lungs. Dr. Grinnan performed a pulmonary function test which revealed an FEV1 of 2.18 liters and a FVC of 3.20 liters. After bronchodilators, Claimant's FEV1 was 2.49 liters. Dr. Grinnan felt that these results were consistent with combined obstructive and restrictive lung disease with a reversible component after bronchodilators. Dr. Grinnan examined a 1993 x-ray and a May 2004 computed tomography scan that Claimant brought with him to the examination. Dr. Grinnan noted that these images showed diffuse nodularity with calcification and apical predominance.

Based on his examination, Dr. Grinnan diagnosed Claimant with silicosis. Dr. Grinnan stated that, given Claimant's occupational history, the pattern depicted in the two images of Claimant's lungs was due to silicosis. Dr. Grinnan disagreed with Dr. Mullins's earlier diagnosis of DIP and stated that such a diagnosis could not accurately be made from the transbronchial biopsies because the pieces were small. Dr. Grinnan further remarked that the reversible

component of Claimant's respiratory disability was not uncommon in patients with silicosis or coal workers pneumoconiosis. He did not assess the extent of any impairment, except to note that Claimants symptoms should be well controlled with inhaled, rather than oral, steroids, and that he did not qualify for oxygen therapy.

West Virginia University Hospitals

In addition to the arterial blood gas study dated July 21, 2004 and summarized above, Employer submitted as treatment records an arterial blood gas study performed by Dr. Harakh Dedhia and dated June 14, 2002. (EX 3). The study appears to have been performed four different times on June 14, 2002, as four different values are reported as Claimant's PCO2 and P02 levels. The first study yielded a PC02 level of 37.0 and a PO2 level of 68; the second PC02 level was 36.7 and the P02 was 63; the third PCO2 was 37.1 and the PO2 was 73; Claimant's fourth PCO2 level was 37.7 and his PO2 level was 85. There is no indication as to whether these levels were obtained during rest or during exercise. Moreover, there is no indication as to the geographic location at which the tests were performed, or the altitude of the testing location, and so the tests are nonconforming.

Discussion and Conclusions of Law

Request for Modification

Claimant's request for modification is governed by § 725.310, which provides that any party may request modification if such request is filed within one year of the denial of a claim. Under § 725.310(a), the terms of the award or denial of benefits can be reconsidered if the party asking for modification can establish a change in conditions or mistake in a determination of fact. In determining whether a "change in conditions" is established, the fact-finder must conduct an independent assessment of the newly submitted evidence (all evidence submitted subsequent to the prior denial) and consider it in conjunction with the previously submitted evidence to determine if the weight of the new evidence is sufficient to establish an element or elements of entitlement previously adjudicated against claimant. *Kingery v. Hunt Branch Coal Co.*, 19 B.L.R. 1-6 (1994). In determining whether a mistake of fact has occurred, the Administrative Law Judge has broad discretion to correct mistakes of fact, whether demonstrated by wholly new evidence, cumulative evidence, or merely further reflection on the evidence initially submitted. *Jessee v. Director, OWCP*, 5 F.3d 723 (4th Cir. 1993).

In the March 1, 2004 decision, the Director found that, while Claimant had been diagnosed with pneumoconiosis, he had not established that he was totally disabled due to pneumoconiosis. Thus, in order to be entitled to modification, Claimant must establish that the Director made a mistake of fact in determining that Claimant had not established total disability due to pneumoconiosis, or that after March 1, 2004, Claimant became totally disabled due to a pulmonary impairment.

Total Disability

Under the applicable regulations, a miner is totally disabled if, in the absence of contrary probative evidence, (1) he has qualifying pulmonary function test results, (2) he has qualifying arterial blood gas test results, (3) he has pneumoconiosis and is suffering from cor pulmonale with right-sided congestive heart failure, or (4) a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that his respiratory or pulmonary condition prevents him from performing his usual coal mine work or work requiring skills comparable to those of any employment in a mine in which he previously engaged with some regularity over a substantial period of time. § 718.204(b)(2). The record contains no evidence that Claimant has cor pulmonale with right-sided congestive heart failure.

Claimant underwent pulmonary function and arterial blood gas tests on several occasions. The only qualifying results were those of the pulmonary function tests performed by Dr. Mullins on March 3, 2004, and the exercise arterial blood gas study preformed by Dr. Rasmussen on September 21, 2005.[17] However, Dr. Mullins's March 3, 2004 pulmonary function test does not meet the requirements of § 718.103(b). Specifically, Dr. Mullin's March 3, 2004 pulmonary function test does not include a tracing of flow versus volume. Accordingly, Dr. Mullins's test cannot be used to determine whether Claimant was totally disabled at the time of the test. § 718.103(c).

Dr. Rasmussen's September 21, 2005 arterial blood gas study yielded the qualifying results of a PCO2 level of 35 and a significantly reduced PO2 level of 61 during exercise. However, Employer has offered evidence which brings into question the results of Dr. Rasmussen's arterial blood gas and demonstrates that, in relying on that evidence, Claimant has not met his burden of proving that he is totally disabled. *See Milburn Colliery Co. v. Director, OWCP [Hicks]*, 138 F.3d 524 (4th Cir. 1998) ("If contrary probative evidence exists, 'the ALJ must assign the contrary evidence appropriate weight and determine whether it outweighs the evidence that supports a finding of total disability.') (quoting *Lane v. Union Carbide Corp.*, 105 F.3d 166, 171 (4th Cir.1997)).

To contradict Claimant's total disability under the regulations, Employer offered evidence that both Drs. Zaldivar and Crisalli questioned the accuracy of the results of Dr. Rasmussen's September 21, 2005 arterial blood gas study. The root of both doctors' concerns was the difference in the PO2 levels in Dr. Mullins's March 2003 exercise test and in Dr. Rasmussen's test. However, Dr. Crisalli's deposition testimony revealed that he was mistaken as to the date of Dr. Mullins's test and believed that it was performed in 2005. Thus, because the interval between tests is significant, his opinion as to the validity of Dr. Rasmussen's results is of impaired probative value, although it is as critical as Dr. Zaldivar's.

[17] Because there is no evidence in the record as to the altitude of the location of the June 17, 2002 arterial blood gas studies, it is impossible to determine whether the results qualify Claimant as totally disabled under the regulations. However, even if these tests were qualifying under the regulations, they do not comply with the requirement under Appendix C to 718 which provides that tests shall not be performed during or soon after an acute respiratory or cardiac illness. As the arterial blood gas study is a hospital record, and because there is no evidence in the record to the contrary, it is reasonable to assume that at the time of the study, Claimant was being treated for a respiratory or cardiac illness.

Dr. Zaldivar was informed of the correct date of Dr. Mullins's study, and his opinion as to the validity of Dr. Rasmussen's arterial blood gas study results is persuasive. Dr. Zaldivar opined that because Dr. Mullins's 2003 arterial blood gas study yielded a PO2 of 101.2 during exercise, there was "no logical explanation for the blood gases to do what they did when Dr. Rasmussen exercised [Claimant]." Dr. Zaldivar also noted that Dr. Rasmussen's pulmonary function test results were "almost normal," and the diffusion capacity as demonstrated by the arterial blood gas study was normal. Dr. Zaldivar opined in some detail that given these circumstances, the only way that the blood gases could have deteriorated to the extent that they did when Claimant exercised for Dr. Rasmussen was if there was a tremendous drop in cardiac output. However, Dr. Zaldivar pointed out that in this case, the anaerobic threshold was normal. Thus, Dr. Zaldivar opined that Dr. Rasmussen's arterial blood gas results were inaccurate.

Unlike Dr. Zaldivar, Dr. Rasmussen did not review Claimant's medical records and did not know that all of Claimant's previous arterial blood gas studies had yielded normal results. On the other hand, Dr. Zaldivar had reviewed Claimant's previous arterial blood gas studies and therefore viewed Dr. Rasmussen's exercise results critically. Further, Dr. Zaldivar's explanation of his doubts was well-reasoned and well-documented. Claimant did not offer any evidence to rehabilitate Dr. Rasmussen's test, to verify the accuracy of the results, or to otherwise rebut Dr. Zaldivar's opinion as to the accuracy of the results. Thus, because Employer has presented evidence which is sufficient to undermine the accuracy of Dr. Rasmussen's arterial blood gas study results, Dr. Rasmussen's test is not sufficient to prove that Claimant is totally disabled.

The only other doctor to opine that Claimant was totally disabled was Dr. Mullins. However, Dr. Mullins's opinions are contradictory and not persuasively reasoned. In Dr. Mullins's first opinion, based on the DOL-sponsored examination on March 26, 2003, she opined that Claimant suffered no pulmonary disability. However, in her March 8, 2004 opinion one year later, after she had followed and treated Claimant because of his breathing difficulties, Dr. Mullins opined that Claimant was totally disabled and unable to return to work. Thus, her opinions are inconsistent, and her rationale for the change is not coherent, unequivocal, or persuasive. Her attempted assessment of Claimant's respiratory problems which resulted in a diagnosis of DIP after biopsy was effectively undermined by Dr. Grinnan's diagnosis of silicosis on referral. Dr. Mullins never established a convincing nexus between pneumoconiosis and Claimant's breathing problems or alleged pulmonary disability. *See Mabe v. Bishop Coal Co.*, 9 B.L.R. 1-67 (1986). Even if Dr. Mullin's reports were not inconsistent, her latter opinion that Claimant is totally disabled is not supported by reference to particular medical evidence and is therefore both unreasoned and undocumented. *See Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989); *Mabe*, 9 B.L.R. 1-67.

The preponderance of the evidence of record supports the conclusion that Claimant does not suffer from total disability attributable to pulmonary impairment or to pneumoconiosis. Because Claimant has not proved a change in conditions or a mistake in a determination of fact, his request for modification of the Director's prior denial, his claim for benefits under the Act must be denied.[18]

[18] Because there is insufficient evidence to establish total disability, there is no need to make a finding as to whether pneumoconiosis exists. However, it should be pointed out that a review of the evidence of record demonstrates that

ORDER

The request for modification and claim of R.R. for Black Lung benefits are denied.

A
Edward Terhune Miller
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, United States Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, United States Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).

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it is likely that Claimant has met this burden. The preponderance of the x-ray evidence supports a finding that simple coalworkers' pneumoconiosis exists. Although Dr. Mullins had originally diagnosed DIP, she seems to recant that diagnosis in her second report. Dr. Crisalli also diagnosed DIP; however, the record demonstrates that he was not afforded the opportunity to study the tissue samples or the pathology report. He seems to rely primarily on Dr. Mullins's original diagnosis. Thus, his opinion regarding DIP is not persuasive. Likewise, Dr. Zaldivar's mention of DIP in his deposition is not sufficient to establish the existence of the disease. At most, Dr. Zaldivar made a differential diagnosis of DIP versus coalworkers' pneumoconiosis, which is an equivocal opinion.